California Health Policy and Data Advisory Commission
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Proposed Minutes
CALIFORNIA HEALTH POLICY AND DATA ADVISORY COMMISSION
And
HEALTH DATA AND PUBLIC INFORMATION COMMITTEE
April 20, 2004

The meeting was called to order at 10:15 a.m. at the Holiday Inn, Oakland International Airport.

Commissioners Present:

William S. Weil, MD, Chair
William Brien, MD
Marjorie Fine, MD
Janet Greenfield, RN
Paula Hertel
Sol Lizerbram, DO
Hugo Morris
Jerry Royer, MD, MBA
Corinne Sanchez, Esq.
Kenneth Tiratira, MD

Absent:

M. Bishop Bastien
Howard L. Harris, PhD

Committee Members:

Vito Genna, Chairperson
Jan Meisels Allen
Vickie Ellis
Denise Hunt
Debra Lowry
Lisa Simonson Maiuro

Staff Present:

CHPDAC: Jacquelyn Paige, Executive Director; and Raquel Lothridge, Executive Assistant

OSHPD: David M. Carlisle, MD, PhD, Director; Mike Kassis, Deputy Director, Healthcare Information Division; Candace Diamond, Manager, Patient Discharge Data Section; Jonathan Teague, Manager, Healthcare Information Resources Center

Also in Attendance: Deborah Kallick, Cedars Sinai Medical Center; Laurie Sobel, CHPDAC Technical Advisory Committee (representing Consumers Union)

OSHPD Director's Report: David M. Carlisle, MD, PhD, Director, OSHPD

- Adding ambulatory surgery and emergency department data to the discharge data base will increase the collection of records from 3.7 million to approximately 12 to 15 million pieces of information per year. This has been a massive undertaking for the Office and is a tribute to the data management capabilities of the system and personnel involved, while at the same time making the data available earlier.

- OSHPD's budget has gone through a Senate budget hearing and is scheduled for the Assembly budget hearing on May 3. The Office is recognized as a special fund supported department. Recently other departments were asked to implement another reduction of General Fund expenditures of approximately three percent. OSHPD was not requested to participate in this process.

  Because of seismic safety deadlines in California, the structural compliance deadline is 2008. The number of plan review requests has tripled, while at the same time staffing levels remained about the same over the past two years. In the current year, OSHPD is hiring 19 new plan reviewers. For the next fiscal year (2004-05), the Governor's proposed budget calls for an additional 32 plan review positions. OSHPD could be the only department that will have a significant proportional increase in staffing.

- There have been some changes in the structure of the Health and Human Services Agency. Secretary Kimberly Belshe has strong support for OSHPD activities. Recent appointments within the Agency include the appointment of Sandra Shewry as Director of the Department of Health Services. Ms. Shewry was formerly the Director of the Managed Risk Medical Insurance Board. Dr. Richard Jackson has been appointed Chief Health Officer for the State of California.

- California is in the midst of a performance review process, an ongoing evaluation of the structure and function of State Government. All facets of the administration are being examined for mechanisms to reduce the cost of government, while increasing efficiency and effectiveness. Recommendations will soon begin to come.

- Hospitals have a structural compliance deadline of 2008, but can apply for deadline extensions of up to five years by demonstrating a compelling community need that could not be met if the hospital complied with seismic safety requirements by closing (i.e., the community would lose needed medical services). Extensions must be requested before January 2007. Many hospitals are using this mechanism to request extensions of the 2008 deadline. At least 134 extension requests have been granted for up to five years maximum (to 2013), and the Office continues to review extension requests.

- The MIRCal process streamlined the processing of discharge data and has significantly improved the availability and timeliness of discharge data. Dr. Carlisle thanked those involved in the MIRCal activity, as well as the collection of emergency department and ambulatory surgery center discharge data.

- The annual report for the Cal-Mortgage program has been submitted to the Health and Human Services Agency for approval. Distribution of the report will be made to CHPDAC upon approval.

- A draft of the first community-acquired pneumonia outcomes report has been submitted for review. This will be the first report to rely on the availability of "do-not-resuscitate orders (DNR)" in the medical record as a risk adjustment variable. DNR is an important predictor of pneumonia outcome. "Condition Present On Admission" is being used to define more carefully a complication by hospitalization versus a co-morbidity, which the patient has brought into the hospital. These variables have allowed researchers to fine tune the administrative data models to a higher degree than other states have been able to accomplish in their outcome reports. Pneumonia has a very high mortality rate, about 12 percent in the current discharge database. Outcomes tend to be correlated with the availability and usage of immediate antibiotic therapy within hospitals.

  The report will be available on the website once it is approved. Dissemination will be discussed with the Health Data and Public Information Committee. Ms. Sobel has some ideas for dissemination to be shared later.

  The next Technical Advisory Committee meeting will be held in late May.

Legislation:

AB 1821 (Cohn) would extend nursing education and training of registered nurses in California by using the Song-Brown family practice training program as a model.

AB 2281 (Cogdill) addresses rural health programs in the State of California. The rural health programs are arrayed across a variety of State Departments. As this bill undergoes amendments, there may be a proposed realignment or restructuring of rural health offices within the State of California.

AB 2632 (Bogh) would exempt from OSHPD review, skilled nursing facilities and projects to repair or replace existing systems or upgrade for efficiency purposes, as well as exempt routine maintenance from review.

AB 2973 (Cohn) would allow hospital projects to be reviewed and approved by agents of the Office and would place a deadline on OSHPD for its review of hospital projects. It would also delegate appeal rights directly to the Building Safety Board.

SB 1626 (Poochigian) would create an annual permit process for facilities review for projects under the $50,000 construction level.

AB 232 and SB 379 address the same subject about how hospitals handle uncompensated care and charity care patients. The bills are slowly moving through the Legislature. At the same time, the industry has embarked on a statewide effort to urge hospitals to work together to develop a standard process for handling patients with bad debt/uncompensated care. There will be some workshops this summer to try to improve processes for handling unsponsored patients.

SB 1487 (Speir), just introduced, would require each hospital to collect data regarding hospital-acquired infections (nosocomial infections) and report quarterly to OSHPD, effective in 2006. The bill would authorize the Department of Health to initiate inspections, upon receipt of a hospital-acquired infections report, to determine whether the health or safety of patients at the facility are at risk, and seek a plan of correction. It also requires OSHPD to submit an annual report to the Legislature in 2007, summarize the data, adjust the reports for patient severity, and compare the reports submitted by other hospitals. These reports would be used to evaluate the quality and accuracy of the information and to periodically review the methods for collecting, analyzing and disclosing this information. The bill calls for an advisory committee to be established, to include affected stakeholders representing a wide range of interested parties.

Currently Pennsylvania and Illinois are creating a similar reporting process. Much of this is patterned after a reporting established by the Centers for Disease Control.

Dr. Fine said the data are currently collected by hospitals for accreditation review purposes. Medicare and the State also require this information, but it is not disclosed to the public.

Motion by Commissioner Greenfield to request a legal counsel report whether CHPDAC can legally advise OSHPD to support or not support a bill. The **motion was seconded and carried**.

There is an ICD-9 coding section to look at nosocomial infections, which are not reported on the discharge data records. There is an incentive to code these infections because there is reimbursement for that additional diagnosis.

Ms. Kallick suggested going to the website (www.leginfo.ca.gov) to determine if there is a written analysis showing pros and cons and supporters for the bill.

SB 2876, sponsored jointly by the California Healthcare Association and the Health Officers Association of California, calls for a limited data set to be constructed with some identifying information. OSHPD could enter into an agreement with the recipient to determine how data would be used, controlled and further disclosed. This bill would override the Information Practices Act and permit hospitals and local public health departments to obtain access to a limited data set.

OSHPD recently eliminated certain data elements in order to make it safer to release to the public. However, hospitals and local public health departments relied upon the more complete database for local disease studies and market share analyses. The law clearly states that local health departments and hospitals are not eligible recipients for confidential

data. The Information Practices Act in the Civil Code does not specifically identify them. OSHPD believes there is a valid reason for these entities to obtain this data.

An initiative is currently being circulated for signature to go on the November 2004 ballot, increasing the telephone bill. The money would go into a Community Clinic Urgent Care Account to be allocated to clinics for expansion, based upon data submitted to OSHPD through the annual utilization reports. OSHPD would be responsible for administering the account and allocating the monies.

Question was asked if the volume of the collection of emergency room and ambulatory surgery data would interfere with the ability to identify the patients. It was explained that HIPAA does not directly impact the discharge data set, but mechanisms to protect privacy and confidentiality were modeled after the HIPAA standards. OSHPD is not a covered entity under HIPAA. This discharge data reporting system is a state-mandated reporting requirement and is exempt from some of the HIPAA requirements. OSHPD wants to be consistent with HIPAA data standards and disclosure. Some of California's disclosure rules are more stringent than HIPAA rules.

Healthcare Information Division Update: Mike Kassis, Deputy Director, Healthcare Information Division

- A "Quick Notes" publication (also on the website) was created to update facilities about MIRCal and the latest developments.

- The Geographic Information System (GIS) project is a three-phased project, which began in 2002. Phase Three is scheduled to be completed in June 2005. Phase Two creates a tool to allow OSHPD to use web-enabled GIS to map and produce reports on healthcare. Some of the healthcare work force data are being used. This system will initially be available to OSHPD staff. However, by the end of Phase Three, it is anticipated that a web-based application will be available to the public.

- Staff has been experimenting with merging data with the Facilities Development Division, especially in the area of seismic safety, and emergency medical services and earthquake data.

- Validation of "condition present on admission" and "do-not-resuscitate" orders will be discussed at the next HDPIC meeting.

- Currently there is about 80-85 percent compliance in reporting by licensed health facilities. Reports from licensed health facilities are due on February 15 annually. Home health agencies reports are due on March 15. The ALIRTS system is the electronic system for collection of these reports. Currently, there is no consequence for non-submitting of reports, except potential suspension of the license. OSHPD has been working with DHS Licensing and Certification Division for a solution.

  Discussion centered on making facilities compliant, and the situation of fairness with reporting. Currently, a facility that has not complied with reporting is listed on the

website as having no report available. Suggestion was made to list all facilities under a heading of noncompliance.

- Several years ago, the Commission supported an increase of the assessment fee from hospitals to the maximum allowable to build up sufficient funds to implement MIRCal and other data improvement activities. Currently, about $7 million is in reserve. The statute says OSHPD is to establish the rate at a level to meet appropriations and maintain a prudent reserve. The reserve is currently too high, and it is proposed to reduce the fee assessed to hospitals and nursing homes to decrease the reserve to $4 million. When the regulations are implemented to lower fees, hospitals and nursing homes will see a reduction in their fee, effective July 2004. OSHPD has the authority to increase the fee to cover costs up to the maximum allowed.

  Question was asked why this reserve could not be used for outcome reporting. It was explained that the problem is the need for more staffing, and the authorization to hire more staff. Consultants are being used for outcome reporting and OSHPD is finalizing a contract with UC Davis to bring on more resources for outcomes reporting.

  If SB 1487 passes, which OSHPD would implement, there could be another increase in fees to accomplish that, which is a regulatory process.

  Question was asked as to why the Committee was asked to give advice about the regulatory process but not about legislation. It was clarified that CHPDAC does advise OSHPD on legislation, but does not advise through motions to take positions on bills. There are some process issues related to CHPDAC's role and responsibility as an advisory Commission.

- Under AB 1627, enacted into law, each hospital is required to make available a written or electronic copy of its charge description master, and to provide a copy of its 25 most commonly charged services or procedures upon request. The charge master and 25 procedures are to be submitted to OSHPD, effective July 2005. Regulations will need to be established to develop this procedure, to be presented at the next HDPIC and Commission meetings for review and approval. A working group has been established to work on details of reporting and disclosure via the website.

  Many Commissioners and committee members thought that the charge master data would be of no benefit. Commissioner Morris made a **motion** to ask OSHPD to analyze the implications of the law and report back on the cost and practicality to be discussed as an agenda item at the next Commission meeting. **Motion was seconded and carried**.

  The purpose of the bill was to provide to patients, health plans and healthcare purchasers more information about charges for hospital care and to discourage hospitals from establishing charges that adversely affect private payers and patients. The charge master probably affects about ten percent of patients entering the hospital who have no insurance or other means of payment for health needs.

A **motion** was made by Commissioner Morris that after receiving a staff report, to decide on whether to hold a public hearing and invite major stakeholders affected by this law to advise on implementation. **Motion was seconded and carried.**

It was suggested that Health Access, the original sponsor of the bill, be invited to make a presentation at the next CHPDAC meeting.

It was explained that before passage of the legislation, CHPDAC had concerns about this legislature. The concerns were captured in the analyses of the bill, and forwarded to the Legislature and Executive Branch. OSHPD cannot unilaterally say it does not like the bill and is not going to implement it. Executive Director Paige said that this is a law, but if it is a law that is not doing what the Commission feels is the intent, now is the time to speak up. Many laws passed under another administration are now being repealed. The California Performance Review does not want to see money spent unnecessarily, and is advising on downsizing departments, personnel, etc.

New Policy on Disclosure of Patient Level Healthcare Data: Mike Kassis, Deputy Director

"It is the policy of the Office to respect the privacy of individuals and to protect the confidentiality of all patient-level healthcare data and the information it collects, uses, and disseminates."

OSHPD's role is to disseminate information, while at the same time protect a person's privacy. When OSHPD receives a request for disclosure of data, the request is reviewed to ensure that disclosure complies with the applicable laws and regulations. Disclosure of patient-level healthcare data may be made to the general public only if it is determined that the data have been de-identified. All other patient-level healthcare data information is considered non-public.

"The Office may restrict the use of patient-level healthcare data and information disclosed to the general public and may prohibit the re-release of the data and information at the patient level."

"Unless specifically provided for by law, the Office will not disclose patient-level healthcare data and information for the purpose of identifying or contacting individuals, or to obtain medical information about specific individuals."

The Office will not disclose non-public patient-level healthcare data and information unless the risks of identification or linkage have been analyzed.

"Disclosure of data and information is limited only to those data and information that are the least confidential and most relevant necessary to accomplish the objectives for which they are requested."

"Use of the data and information will be limited to that described in the request."

"Data and Information will be protected from unauthorized use of disclosure."

"The disclosure is permitted under current laws and regulations, including the Information Practices Act and the Policies of the California Health and Human Services Agency."

CHHSA has an institutional review board (IRB), called Committee for the Protection of Human Subjects. The IRB looks at what is happening to patients in research and how use of data can affect a patient. Researchers file and receive an approved protocol from CPHS.

"The California Health and Human Services Agency's Committee for the Protection of Human Subjects has approved the project for which the data and information are requested."

"The Office's Chief Information Officer approves the disclosure."

"The Office reserves the right to withhold disclosure of any data or information and to recover any data or information previously disclosed."

Commissioner Greenfield made a **motion** to accept the policy.

Discussion: Violation of policy and penalty for unauthorized use or inappropriate use of the data was not spelled out in the policy because the Information Practices Act (IPA) is the governing authority, and there are civil consequences for inappropriate use of data. The IPA governs the agency (Office) and not necessarily the recipient of the data.

A group of researchers from UC Davis looked at the disclosure policies and procedures and observed that there was not "enough teeth in it." Under HIPAA rules, there is a $250,000 fine. The California Medical Information Act deals with providers of the data and how they use/misuse it. There are penalties spelled out in that law, as well as HIPAA.

Detail on security procedures is not included in the policy, but is maintained in procedures.

Motion was seconded and carried.

Proposed Regulations for Emergency Department and Freestanding Surgery Centers: Mike Kassis, Deputy Director, Healthcare Information Division, and Candace Diamond, Manager, Patient Discharge Data Section. Mike Kassis walked the Commission through the proposed changes to the California Code of Regulations.

California Code of Regulations Section 97210 -- Defines contact persons, user account administrator, or designated agent facility identification number. References to hospitals have been changed to "reporting facility" to include freestanding ambulatory surgery centers, which are licensed ambulatory surgery clinics.

California Code of Regulations Section 97211 -- Changes to this section specify that the emergency department and ambulatory surgery care data report collection will be quarterly. Reports will be due 45 days after the end of the quarter.

Hospital inpatient data are collected semi-annually, and due 90 days after the close of the period. It is anticipated that hospital inpatient data reporting soon will be quarterly. The industry medical records personnel and accountants are confident they can meet the 45-day requirement at the end of the period. The responsibility is on the facility to make sure the data are accurate before a final submission to OSHPD. Facilities can log onto OSHPD's test system of error tolerance levels, submit data and make corrections until the error rate is down to the two percent level, and then make a final submission to OSHPD.

Denise Hunt, HDPIC Member, expressed concerns about the 45 days, especially for medical record departments to clean the data before final submission because of high volumes in the emergency department and outpatient surgery areas. Commissioner Janet Greenfield thought it a doable thing for outpatient surgery centers. Commissioner Marjorie Fine thought the biggest problem would be the emergency rooms. Mr. Kassis said at the present time, the time limit is 90 days for inpatient admissions.

For purposes of tracking delinquent reports, reminders, and penalties, the contractor was told there would be a uniform due date. The whole process will begin with the filing of the last quarter of data for 2004. Patients in the ER during October, November and December will be reported February 15, (a 45-day due date) and then request up to 45 extension days. The report period for 2005 will be 45 days plus 28 extension days.

There was no resolution to this at the present time.

California Code of Regulations Section 97212 -- In some cases, changes were necessary to keep definitions in alphabetical order to make it easier to read. In other cases, it was necessary to provide needed definitions for outpatient procedures.

California Code of Regulations Section 97213 -- Defines what must be reported from emergency departments. If a patient comes into an ER and then goes home, there will be a record. If a patient comes into the ER and then is admitted to the same hospital, there will still only be one record, which will be an inpatient admission.

Staff had discussed this reporting issue with national organizations and other states implementing similar regulatory processes. It was clear that most states were struggling with this. If the ER encounter results in a hospital admission, it is entered on the hospital record and then becomes one inpatient admission. There would be no ER record.

Dr. Royer said this would be a major issue for hospitals, where 40 percent of admissions come through the ER. Some of the procedures will be missed in the ER. There will be no evaluation of patients admitted that have big procedures in the ER with regard to promptness, orders being carried out, and correctness of procedures being ordered. Much data will be lost. Mr. Kassis said there would be no time between now and the time to begin collecting the data to devise a mechanism that works.

A hospital would not report an ambulatory surgery data record if the encounter resulted in a same hospital admission. However, there will be a source of admission data element on the inpatient record. Procedures performed on the same day could not be differentiated between inpatient and outpatient settings. If a chart were created that ends when the patient leaves the ER and enters into an inpatient setting, double billing could occur.

If there is hospitalization following ambulatory surgery, it is most likely a complication, and quality could not be tracked. The DRG would be different if diagnoses and procedures from the ER or ambulatory surgery care were not included.

The fact that ambulatory surgery centers do not need to submit an encounter record when there is a complication and the patient is admitted to the hospital looks good, compared to a freestanding surgery center. This needs to be discussed again.

To look at ambulatory surgery data, both the inpatient discharge data set and the ambulatory care data set should be used in conjunction with one another. Suggestion was made to submit an encounter form from the ambulatory surgery center, whether inpatient, freestanding or hospital-based.

Patients who are admitted, discharged to home without complications, and later treated in emergency room could, be tracked by Social Security number and other demographics such as birthdate, age, sex, race, that can be linked. Some diagnoses can be identified years later by ICD-9 codes as a complication from a previous surgery.

California Code of Regulations Section 97215 -- Defines the reporting format to be used.

California Code of Regulations Section 97216 through 97225 -- Defines and clarifies.

California Code of Regulations Section 97226 -- For inpatients, diagnoses will be coded according to ICD-9 CM codes from supplementary classifications of external causes (E-codes) of injuries and poisonings. The M-codes will not be reported as other diagnoses.

California Code of Regulations Section 97227 -- This cleans up the inpatient external cause of injury. When there was an external cause of injury or poisoning, that hospitalization was reported even though the patient may have been seen somewhere else for care.

California Code of Regulations Section 97228 through 97233 – Adds the word inpatient.

California Code of Regulations Section 97240 – Allows emergency department and ambulatory surgery reports to allow adjustments and modifications where facilities cannot comply with reporting requirements this year. Changes the number of extension days allowable to report 2004 data from 45 days to 28 days. For 2005 data, the allowable extension period will drop down to the 14-day extension period.

OSHPD carefully monitors extension requests. For the last report period, only 18 percent of the facilities requested an extension, about nine of which asked for the maximum of 45 days.

California Code of Regulations Section 97244 – Stipulates the method of submission and adds emergency department and ambulatory surgery facilities.

California Code of Regulations 97245 – Facilities have the availability to test their data online before actual submission to OSHPD. Change includes ERs and ambulatory surgery centers.

California Code of Regulations Section 97247 – Approval criteria was changed to delete “hospitals” and insert “reporting facilities.”

California Code of Regulations Section 97248 – Adds an error tolerance level for emergency departments and ambulatory surgery centers. There will be a default so that ambulatory surgery centers will not report “condition present on admission” as a data element.

California Code of Regulations Section 97250 – Changes words “discharge data” to “data report.” Failure to comply pertains to both ERs and ambulatory surgery centers.

The next sections of the proposed regulations spell out the data elements being requested from emergency departments and ambulatory surgery centers. Commitment has been made to be consistent with national standards. ANSI develops standards for electronic interchange of business transactions.

Question was asked as to converting to the national standards for inpatients for race element. In California, mixed race is very diverse and many are of multiple ethnicities, is self-reported. There is more detail under the national standards than is used here. Hospitals are reporting inpatient data using the old categories to OSHPD. Under the national standard, the patient can check more than one box. California only collects the primary ethnicity. When inpatient moves to the national level, the specificity can be revisited and perhaps expanded.

When OSHPD was building its system several years ago, the national standards were unknown. The vendor was told to go ahead and build the outpatient component for OSHPD. The first phase, the inpatient, was based on current standards. OSHPD’s vendor is under time constraints to build a workable reporting system versus trying to make it consistent between inpatient and outpatient.

There was some confusion as to the classifications of “Caucasian” and “white.” Staff will research this.

Mr. Kassis said OSHPD is lobbying to have the “condition present on admission” included in the Healthcare Data Standards Reporting Guide, which would then be available to more states.

California Code of Regulations Section 97264 -- There are 18 dispositions for the emergency department and ambulatory surgery, versus 13 for inpatients. There is no disposition to prison/ jail or residential care facilities for the emergency department. Some ED patients do end up going to jail. Not included in the inpatient is a triaged patient that leaves before being seen by a physician. Also, often patients are discharged to their primary care physician’s office. Staff will look at the standard code to determine if these categories are available in the national standard. If so, they will be inserted. If not, an effort will be undertaken through the Public Healthcare Standards Consortium to lobby for their insertion.

The law does not provide for the collection of financial data such as that collected from hospitals.

There is a code for the inpatient admission that says the patient came from the hospital’s outpatient setting. Suggestion was made to print up information from the database that a

facility had ambulatory care patients, the number of admissions from their ambulatory surgery centers into the hospital. Modify 97213 to indicate separate emergency and inpatient records. Make the final determination after the public hearing input on the regulations. There was some concern as to the cost of doing this.

Motion by Greenfield: Approve draft regulations for emergency department and ambulatory surgery data reporting with reassurance that staff will research the ethnicity issue.

Motion seconded and carried.

Adjournment: The meeting adjourned at 2:23 p.m.